

Productive Provider Newsletter

November-December 2005
Volume 3, Number 10
© MPECS 2005



AT A GLANCE:

In this month's

Productive Provider Newsletter

FRONT PAGE:

It's Just My Opinion

I learned a long time ago that not everyone plays by the same rules . . .

Looking Toward 2006

Changes in coding for the new year . . .

PAGE 4:

Merry Christmas and . . .

It has truly been a fulfilling and exciting experience for me.

Productive Provider Newsletter

is published electronically by
Jim Meeks, P.A.-C. doing business as
M.P.E.C.S.
PO Box 899
Pleasant Grove, Utah 84062-0899
www.mpecs.org

All material contained in this publication is the original work of Jim Meeks, P.A.-C. unless otherwise noted. Quotations from and references to this material are encouraged and authorized as long as credit is given to the author, this newsletter by name and reference to the MPECS web site is included.

Front Page

Its Just My Opinion

Last time in this section of the Productive Provider Newsletter, I unloaded a little bit on coding fears. I illustrated how it was possible and appropriate for us to bill a Level 5 (99215 in the example) visit if we do the work. So, now that I got a few of you stirred up, we have to talk about reality.

The first rule that I learned a long time ago was that not everyone plays by the same rules. I learned that lesson way back in my pre-kindergarten days. Somehow, the rules that I had been taught at my mother's knee about fairness and what is right and what is wrong didn't seem to be observed by others I encountered in my early life experiences. Today, it seems that not much has changed.

We have the same problem with medical coding and billing issues. The rules for coding and documentation are fairly well defined. However, there is no rule that says that an insurance company has to follow those rules. That is also true in some circumstances with the administration of Medicare/Medicaid.

If you will review last months "Its Just My Opinion" article, you will see where I outlined the coding "requirements" for a Level 5 visit of an established patient. This was done according to the written rule. I stated that "Guidelines specifically state that you only have to meet the criteria in two of the three areas (history, exam, decision making) for established patients."

See Opinion on page 2 . . .

Looking Toward 2006

As is always the case, there are a number of changes in coding for the new year. I cannot begin to list all changes here in this newsletter, but I would like to bring some of them to your attention.

To begin with, the AMA version of the ICD-9-CM 2006 was published this year with some errors. There were 118 *proposed* codes included in the published book that were never approved. These codes were supposed to be deleted before the book went to press, but were not. The AMA issued a bulletin listing the invalid codes and recommends that you cross these codes out in your new ICD-9 books. Please visit the AMA web site page (www.ama-assn.org/ama/pub/category/13282.html) for the complete list. These codes do not appear to have been included in books published by other sources. It would still be a good idea to check and make sure.

There are a number of other ICD-9 changes for 2006. I have counted nearly two hundred new codes added to the system, sixty of which are new "V" codes. Twenty one of these new "V" codes describe body mass index findings. You will also discover that there are a number of revised codes and several codes have revised text.

It is important to remember that ICD-9 is updated in April and October every year. It is up to you as a provider to be sure that your billings are using the updated codes. Using the correct ICD-9 code is required under the Health Insurance Portability and Accountability Act (HIPPA).

I have discussed ICD-10 here in the past and there are no new details yet. Please

See 2006 on page 3 . . .

M.P.E.C.S.

Understanding Today's
Healthcare,
Serving Today's
Patients,
Meeting the Needs of
Today's Practice.

MARK YOUR CALENDARS

PRACTICE PROFITABILITY WORKSHOPS and LECTURES:

MPECS is dedicated to making your practice of medicine more productive, more profitable and ultimately more enjoyable. The comprehensive MPECS 4-hour **PRACTICE PROFITABILITY** workshop focuses on exactly what you need to know, the specifics of documentation and coding. If you ever find yourself questioning which E/M code you should use, you need this workshop!

MPECS workshops and lectures are now being scheduled;

UP-COMING MPECS WORKSHOPS;

**Salt Lake City, Utah
May 6, 2006**

CONFERENCE LECTURES;

The 2006 schedule is now open. Please call to schedule a conference event in your area.

The MPECS web site lists the specific details for each **workshop** as it becomes available. Check back often. Register EARLY for significant workshop discounts.

Need a conference speaker? Give us a call. We'll talk!



Opinion

Based on that "rule," I outlined what elements of exam and documentation were required to bill a "Level 5" visit on an established patient. Now for the rest of the story.

What we find in real world application is that insurance companies (and Medicare/Medicaid) often do expect that the medical decision making aspect also meet that level regardless of the history and exam components. Look at it from their perspective. What they receive from providers billing for services is either a paper or electronic claim. The only information on that claim which they can review is the code for the visit (CPT) and the diagnostic code (ICD-9). That is all the information that is submitted unless office/procedure notes are included as well (not the usual way of billing). They have no way of knowing what level of history and exam was performed in your office. That information isn't submitted on the claim form.

The likelihood of submitting a claim with the diagnosis of upper respiratory infection with a 99214 billing code being down graded to a 99213 by an insurance company is pretty high. They will send the reduced payment with an explanation that the diagnosis submitted doesn't correspond with the level of care claimed. This may happen even when you have met the requirements by following the "two out of three" rule (detailed history and detailed exam). The problem is that all they see is a simple diagnosis with billing for a Level 4 exam.

Your primary task for dealing with this is to assure that your documentation supports the level you are billing for and that you have met the established requirements (the detailed history and detailed exam). You must know the E/M coding system. You need to know what is required for any given level you will bill for.

Secondly, you should recognize the limited view insurance carriers have of what is going on during your patient encounter. Their computers and claims review personnel look for claims that fall outside of their criteria and reject those that do.

My recommendation is that you learn to not use general terms when writing a diagnosis. Instead of writing URI as the diagnosis, break it down with descriptive terms such as ear pain, sore throat and cough, etc. Instead of listing only a primary complaint such as hypertension, include all contributing diagnosis that may be applicable to the patient. The patient may also have mixed hyperlipidemia and hypothyroidism. You may not be treating them on this particular visit, but they certainly are (or should be) considered when developing a treatment plan.

If you work in a specialty practice such as dermatology, urology, orthopedics, etc., this applies to you as well. If a patient has several existing health conditions such as those mentioned above, you are surely going to consider those conditions when you are formulating your treatment plan for the condition you are seeing the patient for in your office. This doesn't mean that you have to treat them, but you do acknowledge their existence in the patient and potential for complicating your treatment of the patient.

Evaluating a patient for knee pain in an orthopedic practice is one thing. Evaluating a patient for knee pain that is a diabetic hypertensive is another. It increases the acuity of the patient because you have to consider the risk of complications, morbidity and mortality these conditions present. Again, you don't have to treat these other problems, just give them due consideration. You wouldn't usually prescribe indomethacine to a patient with a history of ulcers. You don't treat the ulcer, you just give it the respect it deserves.

When it comes to writing the diagnosis in the patient chart and on the superbill, the primary complaint (the reason you are seeing the patient) should always be listed first followed by the comorbid and contributing conditions that influence how you are treating the patient.

Its just my opinion. Jim Meeks, P.A.-C.



2006 continued . . .

see the April 2005 Practice Profitability Newsletter (www.mpecs.org/newsletter) for the details that are known. So far, no implementation date has been announced although, legislation is pending that would require adoption of the standard by 2007.

Look for numerous additions, modifications and deletions and such in CPT® codes this year. You will find well over two hundred new “Category I” codes listed in “Appendix B.” There are a few deletions and revisions as well. Be aware that there have been some changes to the Evaluation and Management (E/M) codes. These are listed in “Appendix B” and involve mostly deletion of some consultation codes and code changes for nursing facilities, domiciliary and rest home patient encounters.

I think that we are all well aware of Category I codes, but are you familiar with Category II and Category III codes? Fortunately, their use is optional (for now).

Category II codes are “a set of supplemental tracking codes that can be used for performance. It is anticipated that the use of Category II codes . . . will decrease the need for record abstraction and chart review, and thereby minimize administrative burden on physicians, other health care professionals, hospitals, and entities seeking to measure the quality of patient care. These codes are intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures and that have an evidence base as contributing to quality patient care” (AMA CPT® 2006, pg. 413).

Category II codes have been expanded over what they were in 2005. They include alphabetical characters as the last of 5 characters in the code. And in case you were worried, they have their own modifiers too. A few examples of descriptors for these codes are listed here;

- 1000F Tobacco use, smoking, assessed
- 1001F Tobacco use, non-smoking, assessed
- 2000F Blood pressure, measured
- 2001F Weight recorded
- 2003F Auscultation of the heart performed
- 3000F Blood pressure ≤ 140/90 mm Hg²
- 4002F Statin therapy, prescribed
- and others . . .

Like you, I see where this is going. Performance measurement will be the new frontier for being paid for the work we do every day. As I discussed in the **It's Just My Opinion** section of this newsletter, third party payers have a very limited view of what actually goes on during a patient encounter. This may be their way of looking over our shoulder to see what we are doing.

Category III codes are temporary codes used to document procedures described as “emerging technology, services, and procedures.” These codes are alphanumeric as well with the 5th character being a “T” to indicate the temporary status of the code. Just be aware, if there is a Category III code available, it must be used instead of a Category I “Unlisted Code.”

Be sure not to forget about other codes that you may use often in your practice. If you administer medications or solutions, perform procedures on medicare patients, apply splints and braces or any other medical devices, make sure that your copy of the Healthcare Common Procedure Coding System book (“HCPCS” pronounced hick-picks) is current for the coming year. This coding book lists codes for Durable Medical Equipment, Procedures/Professional Services, Drugs Administered Other Than Oral Method and other specific codes for specific circumstances.

I just checked with our office billing staff to see if they had a copy for 2006. Not yet! We have copies of the ICD-9 and CPT® for 2006, but not the HCPCS. Rest assured it is now being ordered.



DO YOU KNOW?

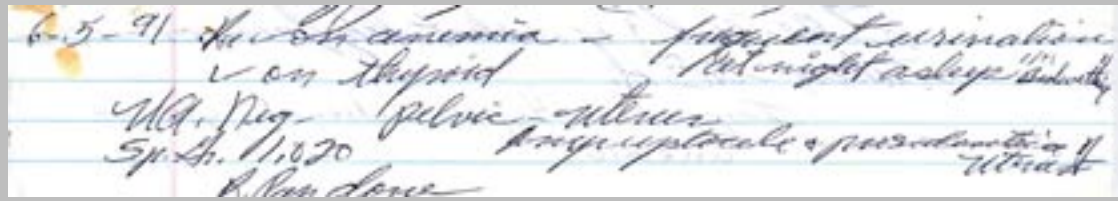
Do you know the specific elements of documentation that determine which E/M code you should use? You are not alone if you are still struggling with this process. Never guess again.

Get the **POCKET CODER**.

A pocket sized quick reference that you can easily refer to in the exam room, the hospital, care center or wherever you are seeing patients. Fully comprehensive, covering all practice settings, it will eliminate guesswork and down coding from your practice.

Order yours today online at www.mpecs.org. It is a must for every provider.





2006

I cannot emphasize enough the importance of having the current copies of these essential books. The challenge we face every day is getting paid for what we do. At every turn, there seems to be another obstacle to getting paid. This shouldn't be one of them. These books are not cheap. They are more expensive than any novel and certainly aren't nearly as interesting. But, the expense of a few hundred dollars for current coding tools will be recovered in a matter of days in most practice settings.

It still amazes me that I occasionally encounter medical practices that are using outdated coding tools. The worst case ever was a busy specialty practice that was using a CPT® book that was more than three years old. The office manager told me that the doctor couldn't justify the expense of a new one and that they typically updated their codes when some surgery or procedure they billed for was rejected by an insurance company or Medicare. That method doesn't sound very efficient to me.

A new **POCKET CODER** is now at the press. As always, these things never seem to get done as quickly as expected. I was hoping for the project to be completed this week, but it looks like it will be another week or two before the printing, binding and such is done. The E/M code changes discussed today are included and will be essential for the success of any practice in 2006. You can pre-order the new **POCKET CODER** on the MPECS web site (www.mpecs.org/products).

MPECS is dedicated to improving your ability to code correctly and with confidence. Let us know how we can help. Visit us at www.mpecs.org. Look for a Productive Provider Newsletter Index on the newsletter page in the near future. I hope that this will help you reference past articles much more efficiently.

HAPPY CODING!



Merry Christmas and Happy New Year!

As this wonderful holiday season quietly approaches, I pause to reflect on the many wonderful people I have had the enormous privilege of meeting and working with this past year. It has truly been a fulfilling and exciting experience for me.

I wish for each of you the happiest of celebrations. May you have those that are most important to you close by your side to enjoy the warmth of family and friendship.

I hope that we will all reflect on those who are working while we are with our families and friends on these holiday days. From the troops who defend this great nation, to the cop on the beat, fire fighters and EMS professionals, nurses, doctors, physician assistants and nurse practitioners to the everyday man and woman on the job everywhere that will spend all or part of their days of celebration away from their families, I salute and honor them for their dedication and selfless service.

May God bless you and your families now and through the new year.

Jim Meeks



"The art and science of practicing medicine is not a business, but there is a business involved in the peripheral aspects of ensuring that the service is delivered."

Greg N. Korneluk, *Practice Enhancement: The Physician's Guide to Success in Private Practice*. [Macmillan Publishing Company, New York, New York, 1985] pg. 263.